TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Metrocrest Surgery Center

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-21-2463-01

Carrier's Austin Representative
Box Number 54

DWC Date Received
August 30, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 26, 2021	Ambulatory Surgical Care Services (ASC), CPT Code 29888 CPT Code 29883 HCPCS Code C1713	$4,219.19	$2,016.42

Requestor's Position

"The following is a breakdown of how this claim should have been processed…

CPT 29888 allows $6096.02 (pays @100%) = $6096.02
CPT 29883 allows $1003.10 (pays @ 50%) = $1003.10
CPT C1713 allows $4549.00 (cost) + $454.90 (10% interest) = $5003.35
Claim Allowed Total = $12102.47
Less Payment of $7883.28
We are owed an additional payment of $4219.19"

Amount in Dispute: $4,219.19

Respondent's Position

"Reimbursement is 235% of service portion for CPT code 29888 ($1746.84 x 2.35) = $4105.07, plus implants CPT C1713 per device portion $2237.49. Invoices for implants were not submitted on the initial audit or appeal, DWC60 packet does not provide invoice for implants.

Audit is consistent with Rule 134.402-Ambulatory Surgical Center Fee Guideline. No additional payment."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.402 sets out the fee guidelines for ambulatory surgery center services.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 763 – Payment is being allowed per the device intensive methodology
- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-59 – Processed based on multiple or concurrent procedure rules.
- D25 – Approved non-network provider for WorkWell, TX Network claimant per Rule 1305.153 (c).
- 615 – Payment for this service has been reduced according to the Medicare Multiple Surgery Guidelines.
- 763 – Paid per ASC FG at 235%. Implants not applicable or separate reimbursement (w/signed cert) not requested: Rule 134.402 (g)
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- DC4 – No additional reimbursement allowed after reconsideration.

- DC4 Notes: "THE PAYMENT MADE PER DEVICE INTENSIVE METHOD 235% OF SERVICE PORTION OF 29888 $4082.77 WITH THE DEVICE PORTION ON IMPLANT LINE ($2237.49) AND 29883 AT 235% OF MAR X THE ASC MULTIPLE PROCEDURE RULE $1537.05 = TOTAL AMOUNT OF $7883.28 IS GREATER THAN THE PAYMENT AT

DEVICE INTENSIVE METHOD PLUS IMPLANTS – 29888-235% OF SERVICE PORTION ($4082.77) OF MEDICARE'S GEOGRAPHICALLY ADJUSTED FULLY IMPLEMENTED RATE IMPLANTS: 1-TIGHTROPE @ $370.00, 1 button $224.00, 1-8X30MM SCRUEW $340.00, 1 PEEK SCREW $425.00 X 10% = $1494.90. 29883 @ 153% OF MAR X ASC MULTIPLE PROCEDURE RULE = $1000.72 FOR A TOTAL REIMBURSEMENT OF $8578.39.

Issues

1. Is Metrocrest Surgery Center entitled to additional reimbursement?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $4,219.19 for ASC services rendered on May 26, 2021. Metrocrest Surgery Center requested separate reimbursement for implantables.

   Per explanation of benefits dated August 19, 2021, the respondent contends that additional reimbursement is not due because payment of $7,883.28 was made per the fee guideline.

   The fee guidelines for disputed services are found in 28 TAC §134.402.

   A. Per Addendum AA, CPT codes 29888 is a device intensive procedure.

      28 TAC §134.402(f)(2)(B)(i)(ii) states,

      > The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the ASC service portion multiplied by 235 percent."

      The following formula was used to calculate the MAR:

      - Step 1 calculating the device portion of the procedure:

        The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) code 29888 for CY 2021 = $6,264.95.

        The device dependent APC offset percentage for National Hospital OPPS found in Addendum P for code 29888 for CY 2021 is 38.24%

        Multiply these two = $2,395.72.

- Step 2 calculating the service portion of the procedure:

  Per Addendum AA, the Medicare ASC reimbursement rate for code 29888 for CY 2021 is $4,035.99.
  This number is divided by 2 = $2,018.00.

  This number multiplied by the City Wage Index for Carrollton, Texas of 0.9744 = $1,966.34.

  The sum of these two is the geographically adjusted Medicare ASC reimbursement =$3,984.34.

  The service portion is found by taking the geographically adjusted rate minus the device portion = $1,588.62.

  Multiply the service portion by the DWC payment adjustment of 235% = $3,733.26.

- Step 3 calculating the MAR:

  The MAR is determined by adding the sum of the reimbursement for the device portion and the service portion = $6,128.98.

  The DWC finds the MAR for CPT code 29888 is **$6,128.98**.

B. Per Addendum AA, CPT code 29883 is a non-device intensive procedure.
28 TAC §134.402(f)(1)(B) states,

> Reimbursement for non-device intensive procedures shall be: if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of: (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent.

The following formula was used to calculate the MAR:

The Medicare ASC reimbursement for code 29883 CY 2021 is $1,328.25.

The Medicare ASC reimbursement is divided by 2 = $664.13.

This number multiplied by the City Wage Index for Plano, Texas of 0.9744= $647.13.

Add these two together = $1,311.26.

To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 153% = $2,006.23. This code is subject to multiple procedure rule discounting of 50% = $1,003.12.

The DWC finds the MAR for CPT code 29883 is **$1,003.12**.

C. The requestor billed for the implantables with HCPCS code C1713.

Per 28 TAC §134.402(f)(1)(B) the following formula was used to calculate the MAR:

Implant (Per Operative Report)	No. Of Units	Cost	Cost + 10%
Arthrex TightRope Button Extender	1	$225.00	$247.50
Arthrex ABS Button Round 14 mm Concave	1	$224.00	$246.40
Arthrex 8 mm x 30 mm BioComposite interference screw	1	$422.00	$464.20
Arthrex IMPLS FIXATN PEEK SwiveLock 4.75x19.1	1	$725.00	$797.50
Stryker AIR meniscal repair device-curved up	1	$460.00	$506.00
Stryker AIR meniscal repair device-curved down	1	$460.00	$506.00
Total		$2,516.00	**$2,767.60**

The DWC finds the MAR for the ASC services rendered on May 26, 2021 is $9,899.70. The respondent paid $7,883.28. The DWC finds the requestor is due additional reimbursement of $2,016.42.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of $2,016.42 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Texas Mutual Insurance Company must remit to Metrocrest Surgery Center $2,016.42 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 9, 2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel*

a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD) and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.